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(54) **METHODS FOR PHOTODYNAMIC THERAPY**

(71) Applicant: **DUSA Pharmaceuticals, Inc.**, Billerica, MA (US)

(72) Inventors: **Scott Lundahl**, Lexington, MA (US);
Michael Guttadauro, Carlisle, MA (US)

(73) Assignee: **DUSA PHARMACEUTICALS, INC.**, Billerica, MA (US)

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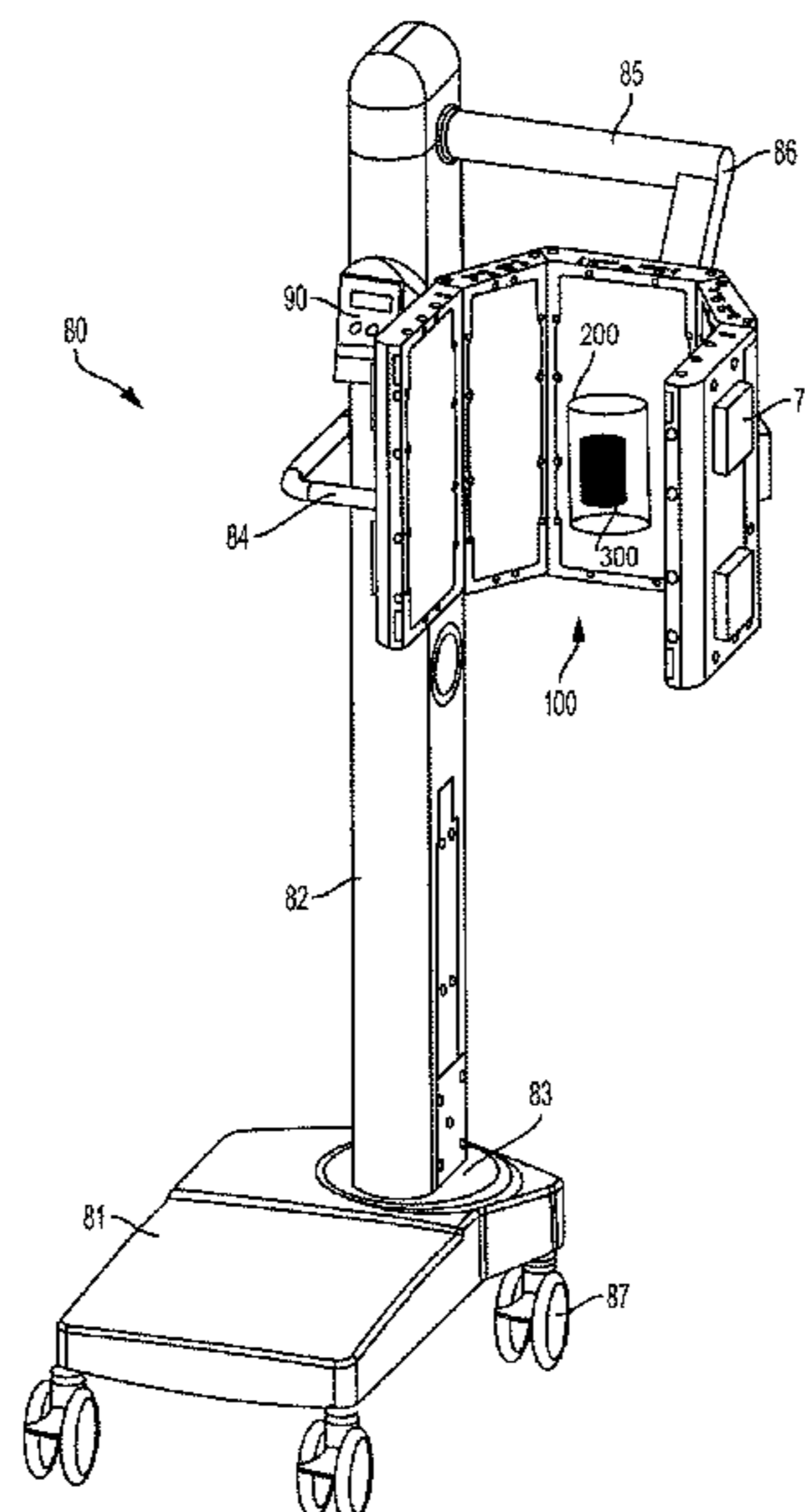
Primary Examiner — Ahmed M Farah

(74) *Attorney, Agent, or Firm* — Foley & Lardner LLP

(57) **ABSTRACT**

A method of enhancing penetration of a topical composition of 5-aminolevulinic acid (ALA) into tissue for photodynamic therapy includes topically applying ALA to a treatment area to be treated with photodynamic therapy. The method further includes, after the ALA is applied to the treatment area, covering the treatment area with a low density polyethylene barrier. The treatment area is covered with the low density polyethylene barrier prior to light treatment to minimize transepidermal water loss from the treatment area.

18 Claims, 12 Drawing Sheets



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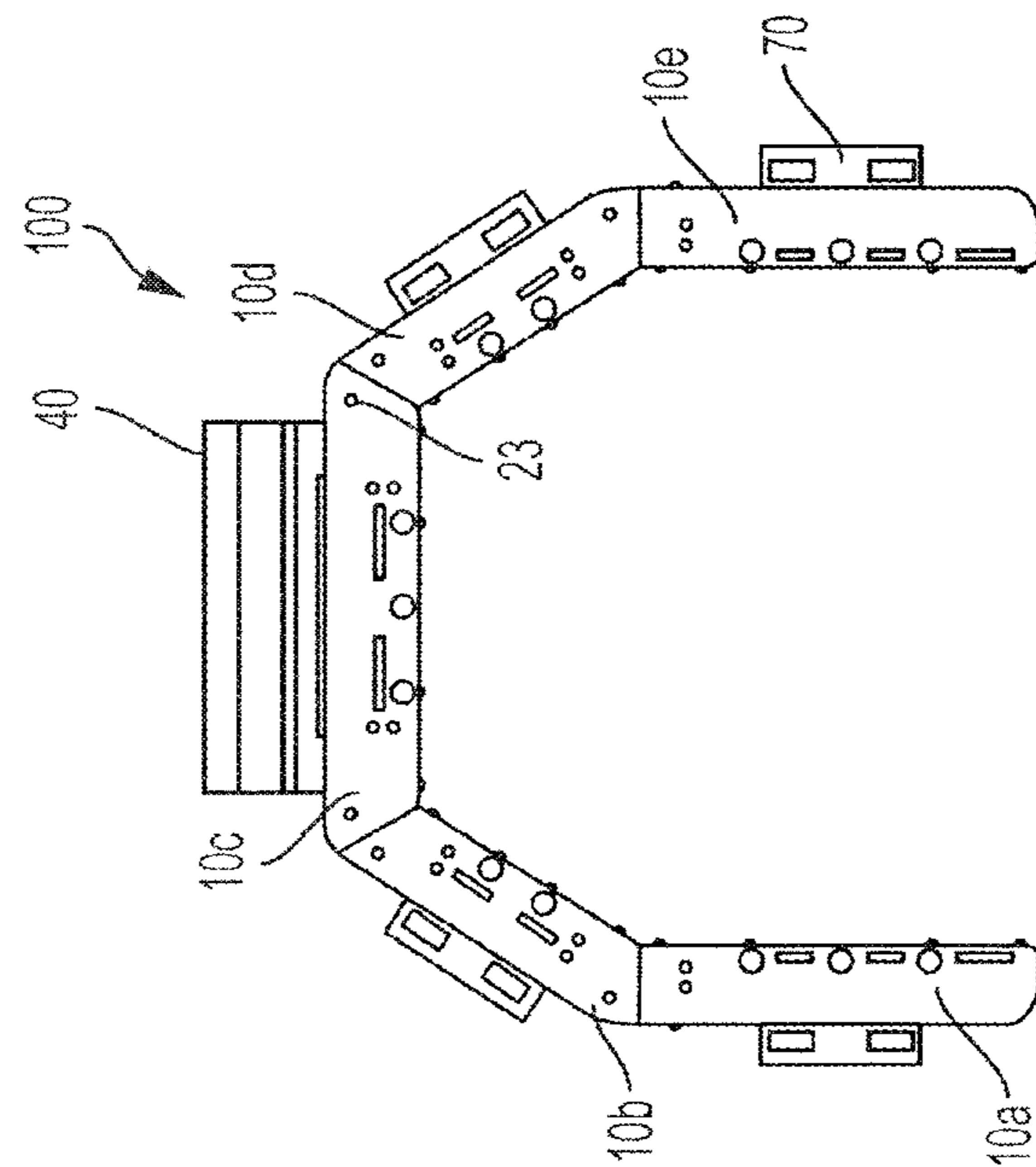


FIG. 1A

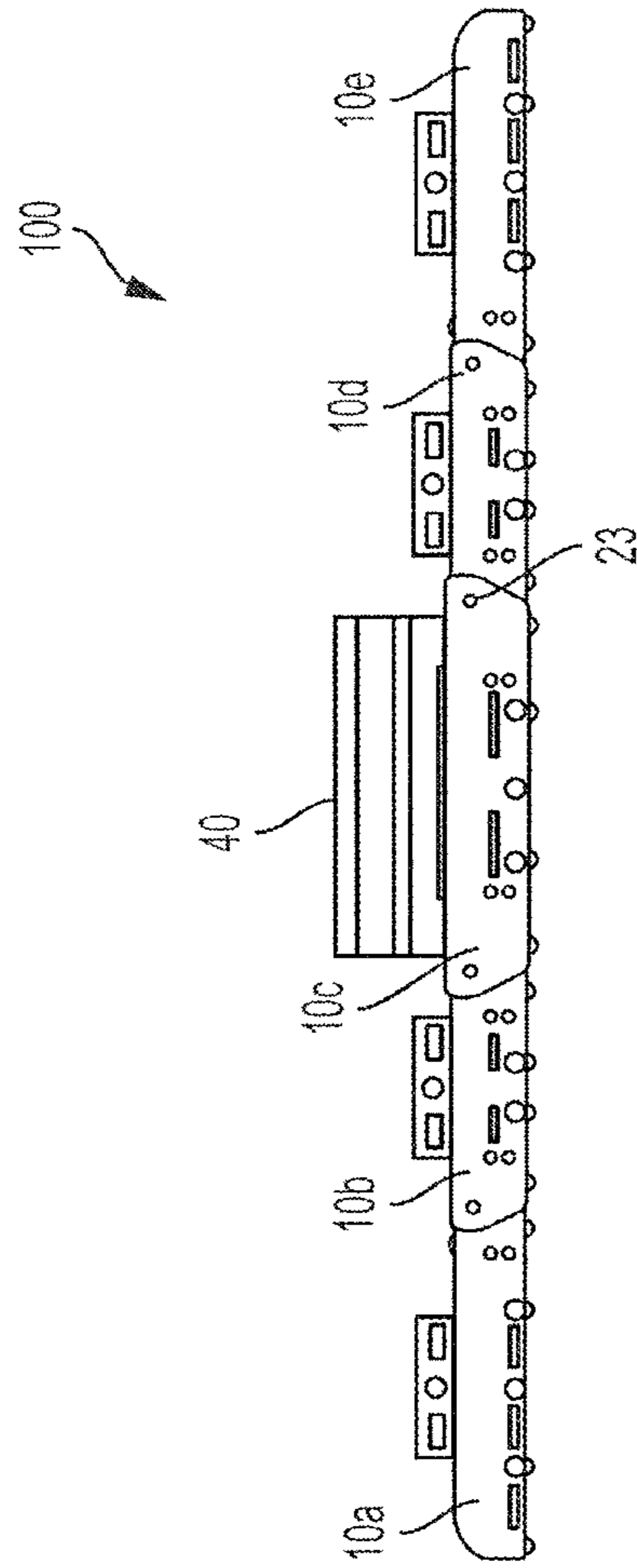


FIG. 1B

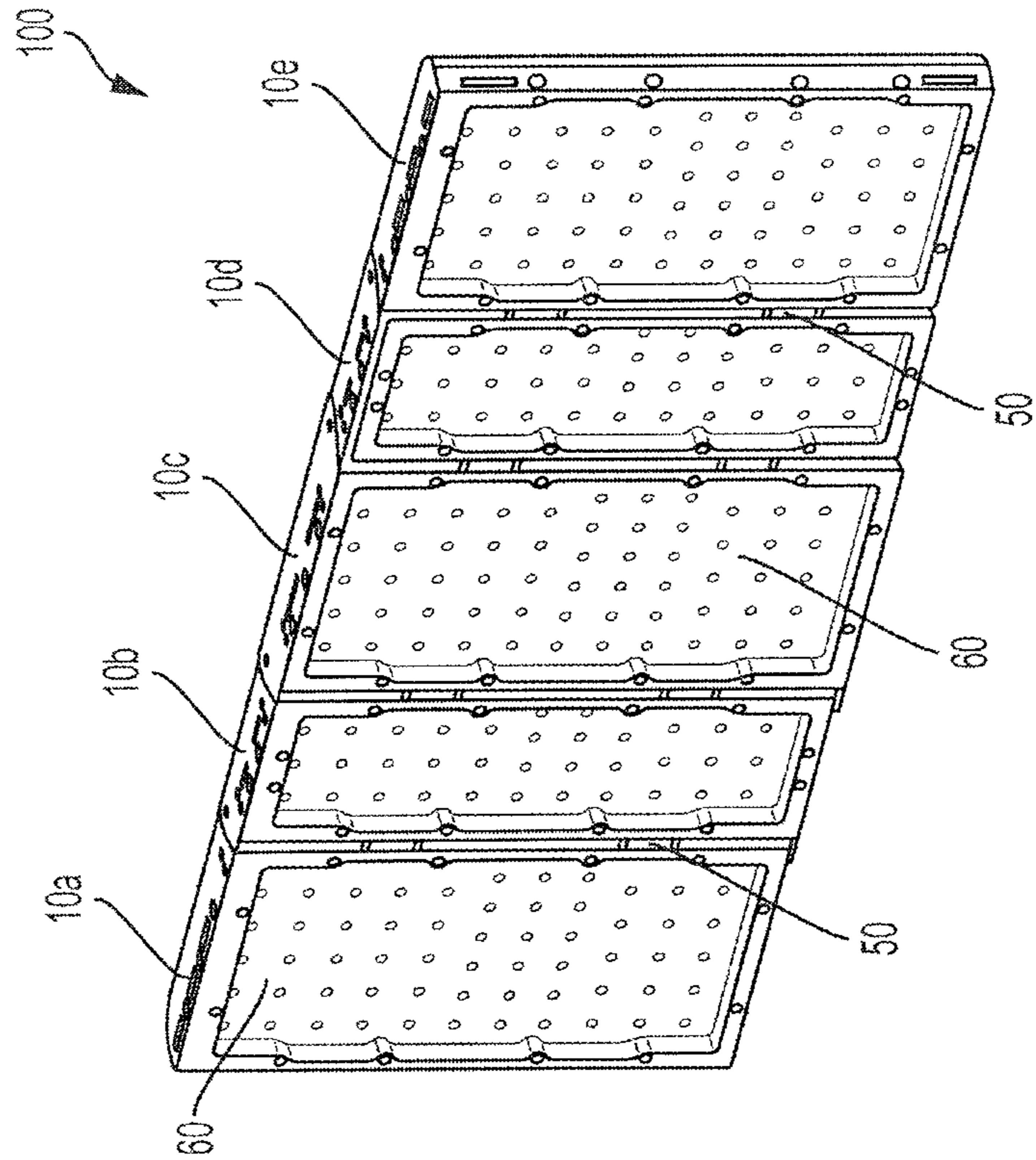


FIG. 2B

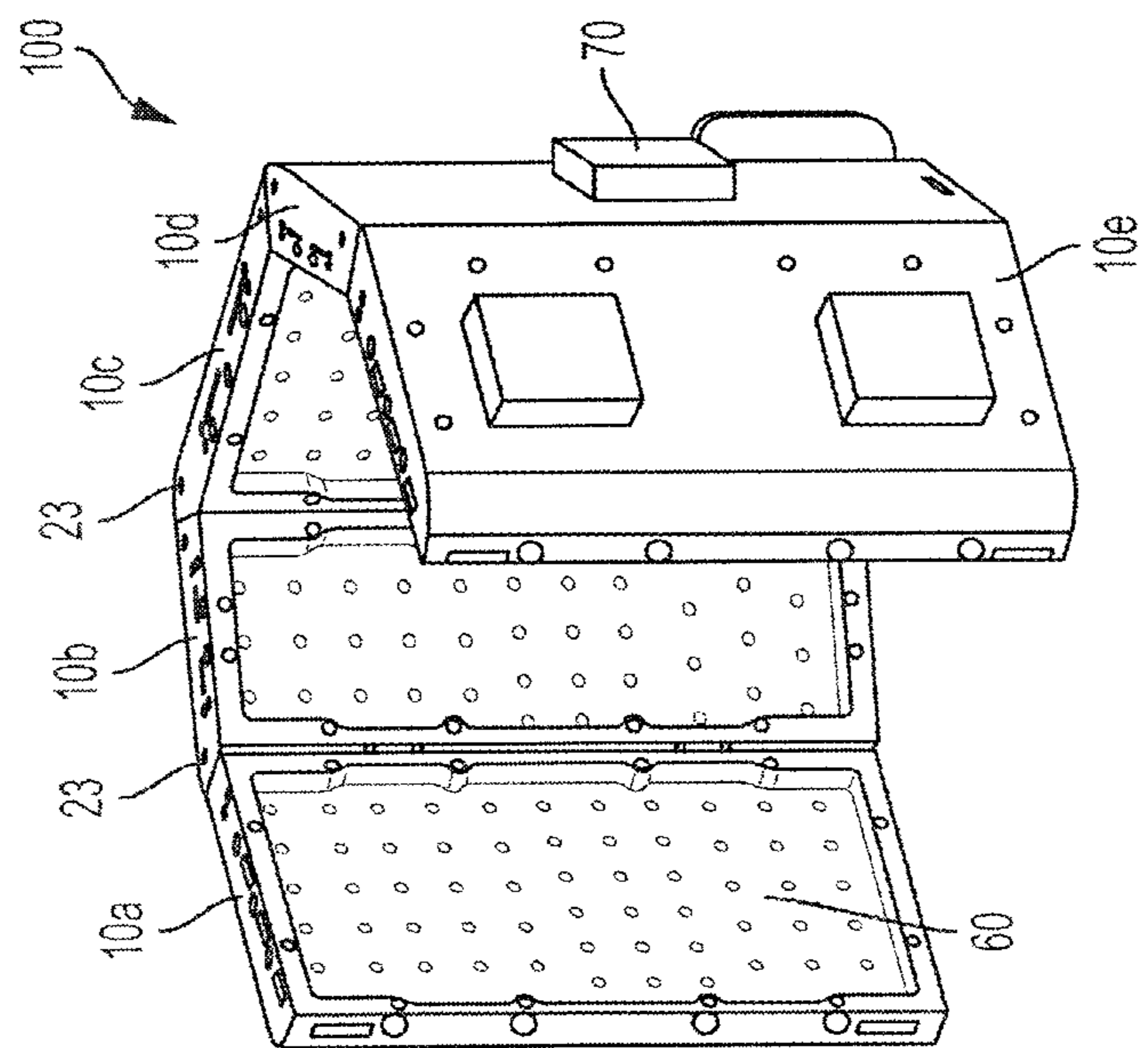


FIG. 2A

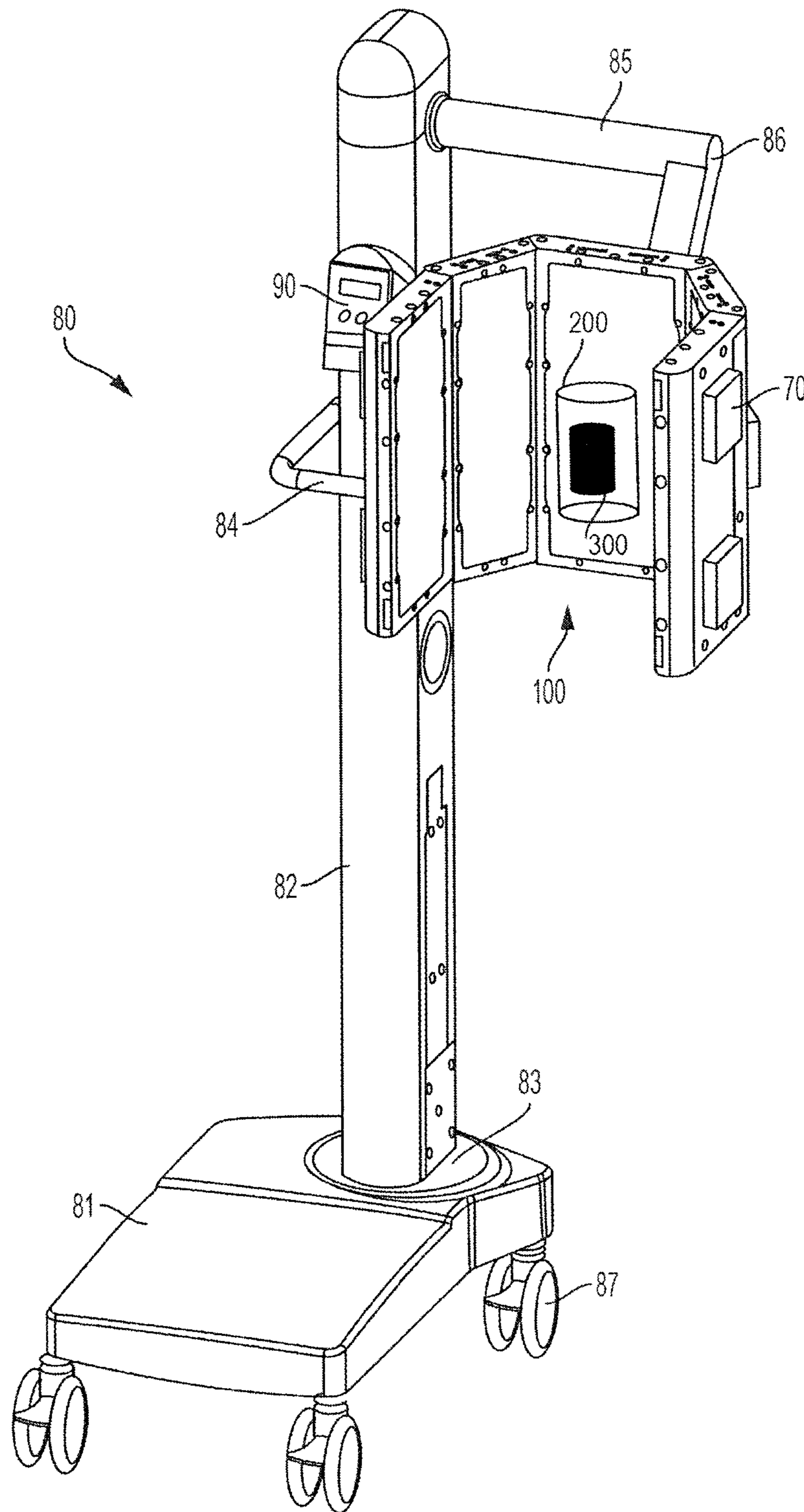


FIG. 3

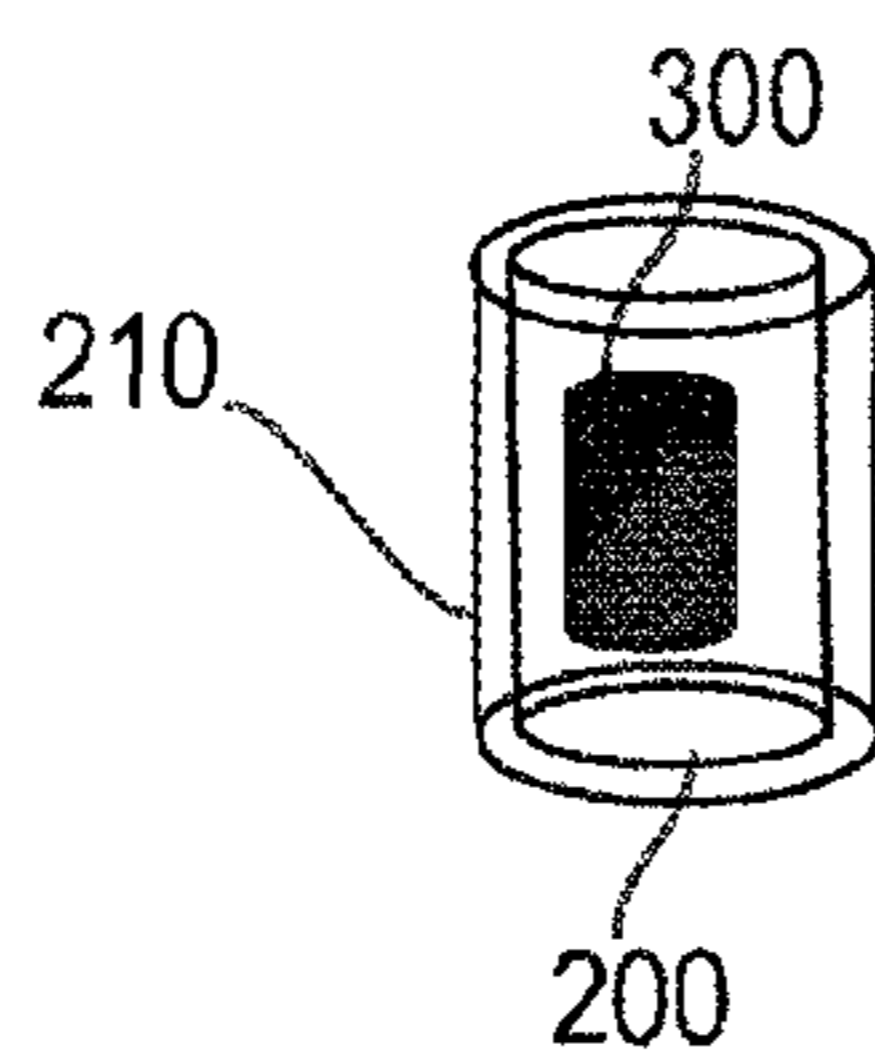


FIG. 4

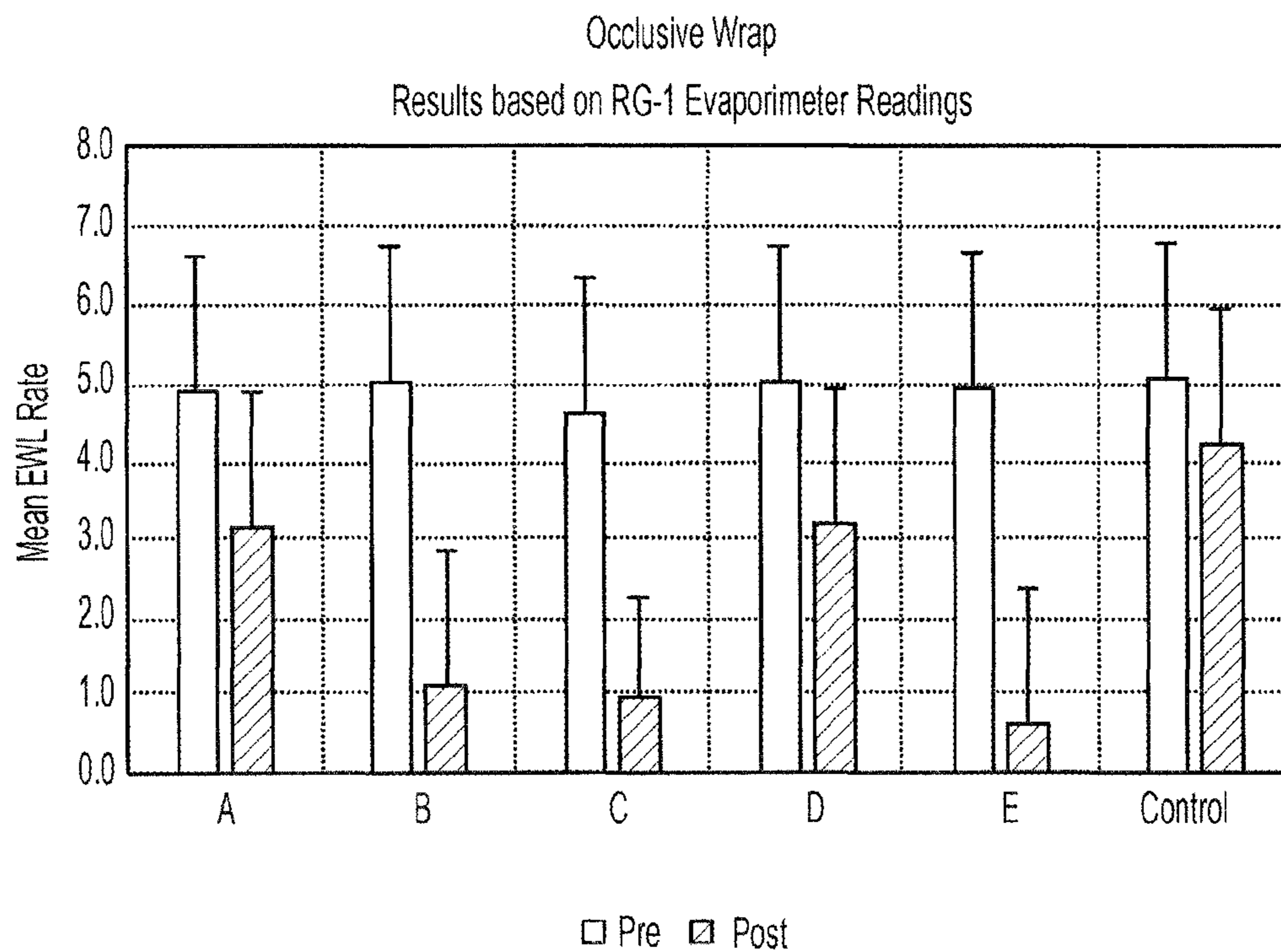


FIG. 5

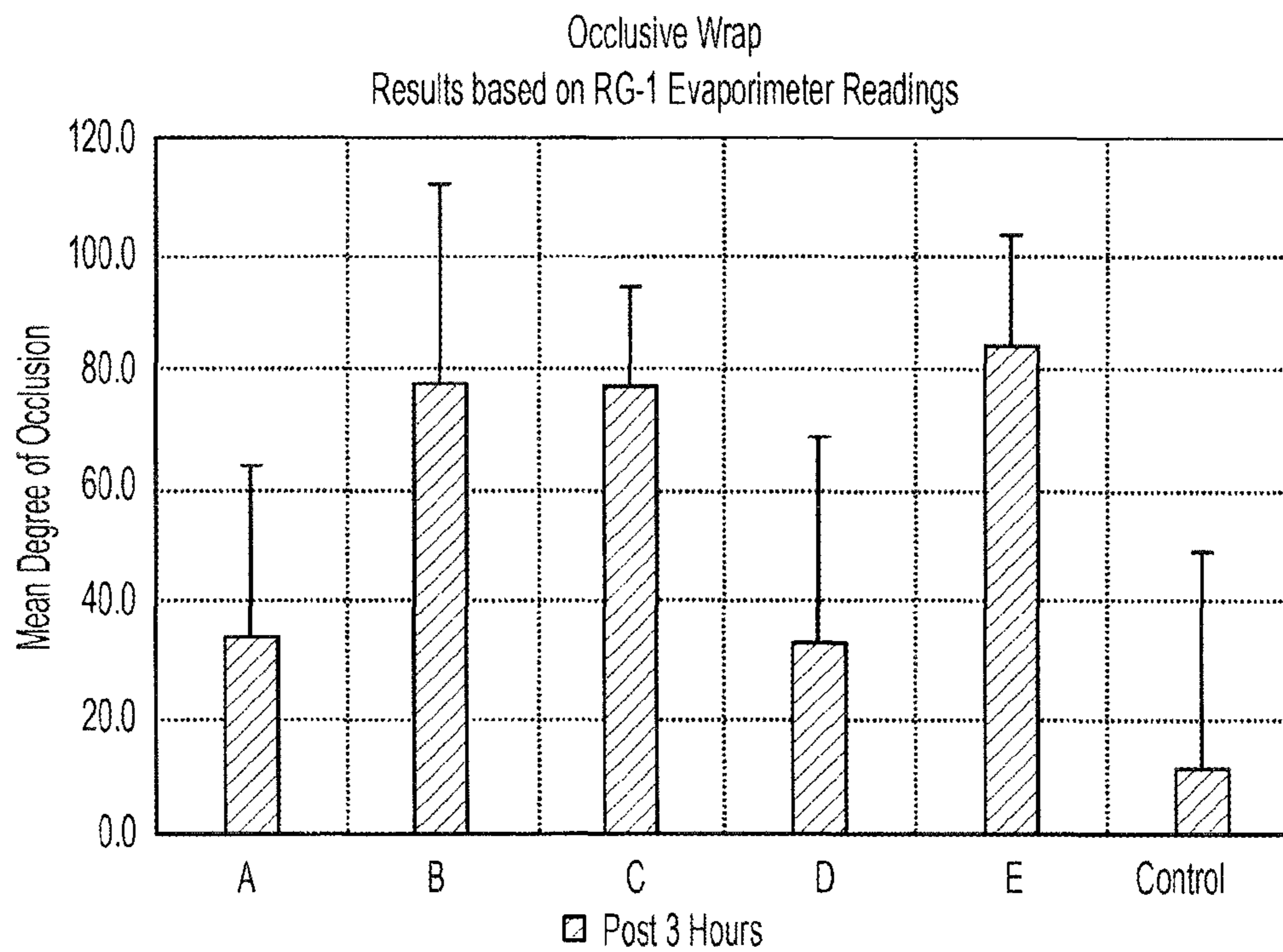


FIG. 6

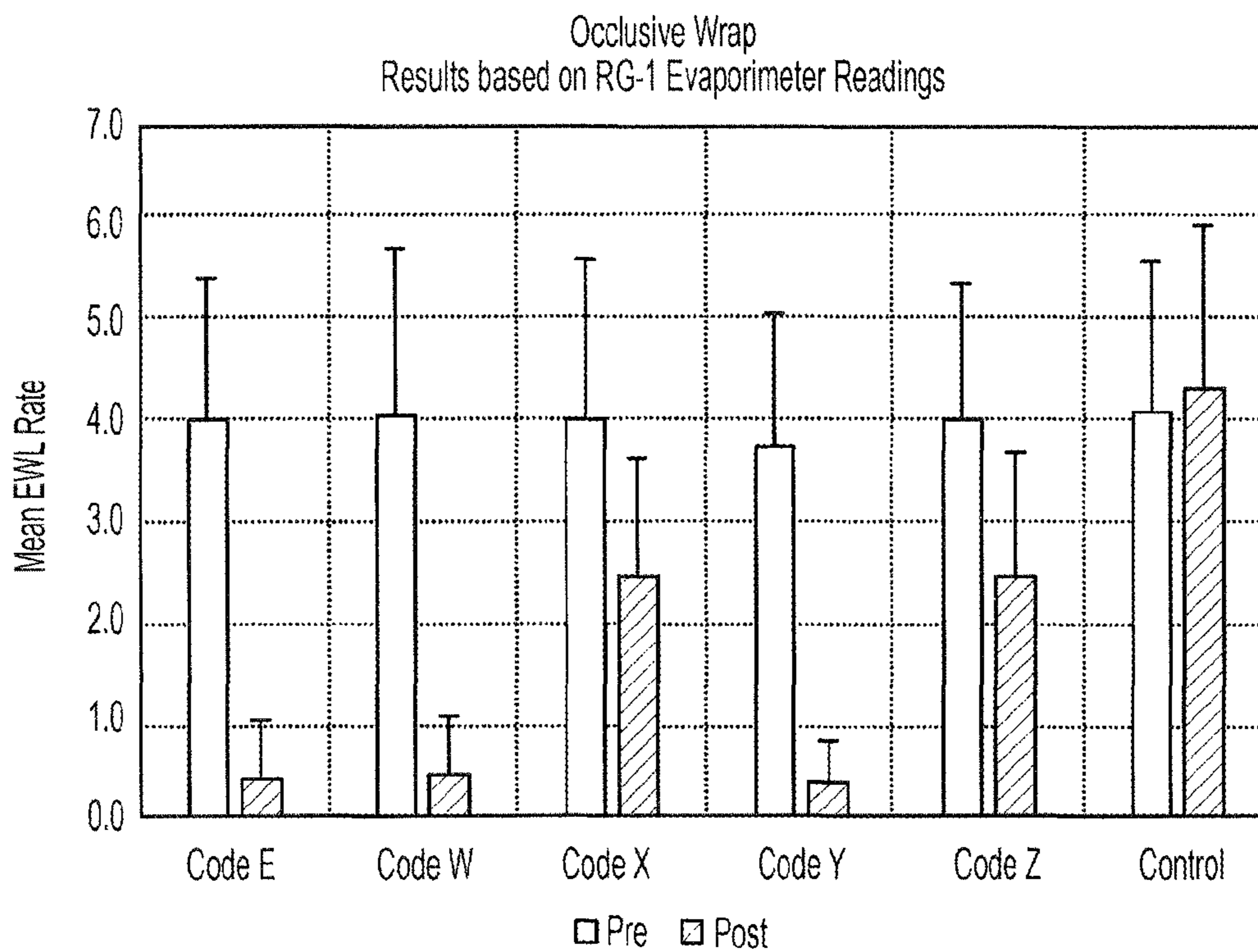


FIG. 7

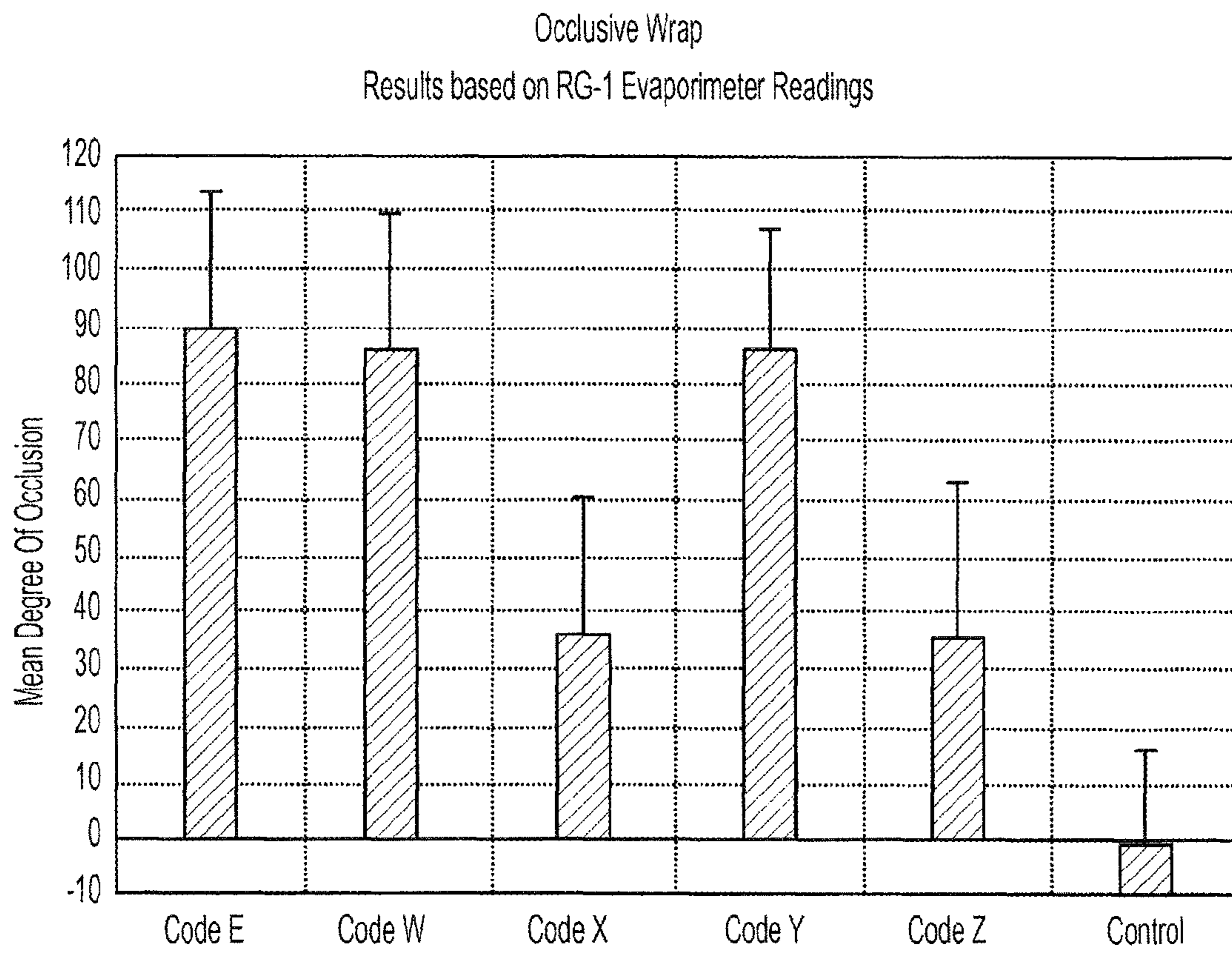


FIG. 8

FIG. 9

Water Loss Baseline

#	SN#	A	B	C	D	E	Control
1	SN004	3.4	3.2	4.0	5.3	4.3	4.5
2	SN002	3.9	5.2	3.4	5.7	3.1	4.5
3	SN001	4.7	3.6	4.1	4.1	3.9	3.1
4	SN006	6.5	6.8	7.2	6.6	5.6	7.3
5	SN010	6.7	6.0	6.2	7.2	6.3	6.3
6	SN012	3.9	3.6	3.9	4.6	4.1	4.3
7	SN020	7.9	8.2	6.8	6.0	9.2	7.9
8	SN025	3.1	3.8	3.3	3.7	4.0	3.4
9	SN013	5.0	3.4	5.2	3.9	5.2	3.8
10	SN003	4.0	3.8	3.1	3.8	3.8	5.1
11	SN026	8.6	6.6	6.4	6.6	8.0	8.2
12	SN015	3.5	3.1	6.3	4.9	3.5	2.9
13	SN011	2.1	3.7	1.3	2.7	2.8	2.3
14	SN014	6.1	5.0	4.0	4.9	4.3	7.3
15	SN007	3.7	4.0	3.3	4.6	3.6	3.4
16	SN009	4.5	4.1	3.1	3.3	3.9	4.7
17	SN031	3.4	4.6	5.0	4.3	2.6	5.5
18	SN008	5.6	4.4	5.9	6.9	5.6	6.3
19	SN017	8.1	6.1	6.0	9.4	6.8	7.5
20	SN035	8.3	7.7	7.9	7.3	9.2	8.4
21	SN018	4.4	4.7	4.7	3.2	4.7	5.4
22	SN024	4.5	6.1	5.6	2.7	4.9	3.6
23	SN029	4.1	4.2	5.9	3.7	5.3	6.0
24	SN019	2.2	5.7	2.4	3.6	4.9	3.3
25	SN021	5.8	6.0	4.1	5.4	6.5	5.8
26	SN027	4.3	6.3	5.6	5.9	5.0	4.3
27	SN028	5.5	3.8	2.9	4.3	4.0	2.4
28	SN033	2.4	3.9	1.2	3.3	1.9	1.7
29	SN030	6.0	4.4	4.9	5.8	4.0	5.2
30	SN023	4.6	8.8	4.3	5.9	7.2	7.1
	Mean	4.88	5.02	4.60	4.99	4.93	5.06
	SD	1.78	1.54	1.67	1.58	1.79	1.88

FIG. 10

Water Loss Post 3 Hours
Wear Time

#	SN#	A	B	C	D	E	Control
1	SN004	2.7	0.4	0.6	2.7	0.5	3.6
2	SN002	3.0	1.2	1.9	1.5	0.5	4.7
3	SN001	2.8	0.1	1.2	2.7	0.3	3.3
4	SN006	2.4	1.5	0.9	4.1	0.4	5.7
5	SN010	5.1	1.8	0.5	3.8	0.2	5.5
6	SN012	2.9	0.8	0.8	2.7	0.2	4.0
7	SN020	4.6	0.3	1.8	4.5	0.7	6.0
8	SN025	0.6	0.8	1.1	2.7	0.4	3.0
9	SN013	7.0	1.8	3.3	7.5	1.2	3.6
10	SN003	1.9	0.6	0.2	1.6	0.9	2.8
11	SN026	6.5	9.1	1.3	4.5	0.2	8.3
12	SN015	0.9	0.6	1.7	1.0	0.5	5.4
13	SN011	1.6	0.6	0.6	1.2	2.5	0.6
14	SN014	3.7	0.1	0.9	2.2	0.6	2.9
15	SN007	3.5	6.0	0.9	3.7	0.0	1.7
16	SN009	2.4	0.2	0.3	4.3	0.5	4.3
17	SN031	1.1	0.4	1.9	4.4	0.5	2.0
18	SN008	3.5	0.6	1.5	1.0	0.5	6.1
19	SN017	4.1	0.3	0.8	6.1	3.8	4.8
20	SN035	1.9	0.1	0.7	5.0	0.1	3.9
21	SN018	3.5	0.6	-0.8	1.8	0.3	5.4
22	SN024	2.6	0.0	1.5	3.7	0.2	2.0
23	SN029	3.3	-0.1	0.3	2.5	1.1	5.2
24	SN019	2.8	0.2	0.1	2.3	1.1	5.6
25	SN021	3.8	1.0	0.9	3.3	0.1	6.2
26	SN027	0.9	0.7	1.0	3.4	0.9	4.0
27	SN028	4.3	0.2	1.3	3.6	0.5	3.2
28	SN033	0.9	1.9	0.4	1.1	0.7	3.1
29	SN030	4.3	0.8	0.8	4.7	0.0	3.1
30	SN023	5.5	0.8	0.3	1.9	0.7	6.8
	Mean	3.14	1.11	0.96	3.18	0.67	4.22
	SD	1.61	1.88	0.73	1.57	0.76	1.69

FIG. 11

Degree of Occlusion at Post 3 Hours Wear Time

#	SN#	A	B	C	D	E	Control
1	SN004	21.4	89.1	84.4	48.3	88.0	21.3
2	SN002	21.7	77.4	43.1	73.9	84.1	-4.9
3	SN001	39.0	97.4	71.1	35.6	93.3	-6.7
4	SN006	63.0	78.1	87.4	37.0	93.0	22.6
5	SN010	24.7	69.6	91.3	46.8	96.8	12.8
6	SN012	24.7	78.5	80.5	40.1	94.4	5.5
7	SN020	41.9	96.9	73.6	24.5	92.7	24.4
8	SN025	79.8	79.7	68.2	27.2	89.5	12.1
9	SN013	-40.4	47.7	37.0	-92.5	76.8	6.1
10	SN003	52.2	84.7	93.6	58.6	77.6	44.7
11	SN026	24.1	-37.8	79.8	32.3	97.9	-0.4
12	SN015	74.0	81.2	72.6	80.2	84.8	-82.6
13	SN011	22.5	85.2	51.5	56.0	12.3	73.5
14	SN014	39.3	98.3	77.8	55.7	85.0	60.0
15	SN007	3.7	-51.5	73.1	20.0	98.8	49.9
16	SN009	46.0	94.5	90.0	-32.0	86.8	8.3
17	SN031	66.8	91.9	62.5	-1.2	80.2	63.8
18	SN008	37.7	85.7	74.0	85.3	91.8	2.9
19	SN017	49.3	94.8	86.1	35.0	45.0	36.1
20	SN035	76.9	98.2	90.6	31.4	98.8	53.6
21	SN018	19.7	88.2	115.9	43.9	93.6	-1.0
22	SN024	42.8	100.2	73.9	-34.4	96.5	44.9
23	SN029	18.7	101.6	94.4	32.6	80.1	13.7
24	SN019	-31.4	96.4	94.3	37.7	77.4	-68.8
25	SN021	34.5	83.2	77.5	39.3	97.9	-7.9
26	SN027	78.8	88.2	82.7	41.7	82.0	7.5
27	SN028	22.4	93.9	57.0	15.7	88.3	-34.6
28	SN033	60.8	52.2	64.4	67.6	61.9	-76.7
29	SN030	29.6	80.7	83.5	18.6	99.3	40.1
30	SN023	-20.9	91.1	92.9	68.3	90.8	5.4
	Mean	34.10	77.18	77.50	33.11	84.51	10.85
	SD	30.03	35.45	16.48	36.20	17.92	38.45

FIG. 12

Water Loss Baseline

#	SN#	Code E	Code W	Code X	Code Y	Code Z	Control
1	SN007	3.6	5.6	6.3	5.8	6.0	5.6
2	SN012	5.0	4.3	3.3	4.0	4.2	3.4
3	SN001	3.5	1.4	2.1	1.3	2.5	1.1
4	SN002	2.0	1.9	2.1	1.3	2.2	4.0
5	SN008	6.1	5.8	4.1	4.4	5.8	6.3
6	SN011	5.8	3.6	3.4	2.6	4.3	3.6
7	SN006	2.5	2.6	2.1	3.2	1.2	2.0
8	SN003	3.1	4.9	2.8	3.8	2.9	2.4
9	SN005	4.7	8.0	5.8	6.2	6.4	6.2
10	SN010	4.1	4.6	4.7	3.8	3.6	4.2
11	SN016	1.9	2.1	1.2	3.4	1.7	3.0
12	SN038	2.6	2.7	2.8	3.4	3.5	3.0
13	SN013	3.5	4.7	6.7	5.1	4.1	4.6
14	SN031	2.3	1.7	1.2	2.4	2.3	2.3
15	SN024	3.5	3.5	3.3	3.8	2.6	4.0
16	SN023	7.5	7.6	9.0	5.8	7.6	7.8
17	SN025	5.3	5.0	5.1	3.8	6.1	6.5
18	SN014	4.0	2.0	2.7	5.4	3.3	3.9
19	SN026	2.4	2.4	2.7	2.3	3.4	3.1
20	SN015	2.1	1.9	2.8	1.7	2.3	2.1
21	SN037	5.3	4.8	4.2	5.8	5.1	5.4
22	SN021	4.2	3.7	4.6	3.1	4.3	4.3
23	SN022	4.0	3.0	5.2	2.3	3.3	4.0
24	SN033	5.8	5.5	4.6	4.0	4.4	5.5
25	SN018	4.1	4.2	4.6	3.6	5.2	4.4
26	SN020	3.8	5.1	4.2	4.0	4.4	3.9
27	SN034	3.3	3.6	4.1	3.6	4.9	4.3
28	SN028	5.1	3.6	6.5	5.3	5.1	4.7
29	SN027	4.7	6.1	5.6	3.3	3.9	3.4
30	SN029	5.3	5.4	3.5	4.1	4.9	4.7
	Mean	4.04	4.04	4.04	3.76	4.04	4.11
	SD	1.38	1.71	1.76	1.33	1.50	1.49

FIG. 13

Water Loss
Post 3 Hours Wear Time

#	SN#	Code E	Code W	Code X	Code Y	Code Z	Control
1	SN007	0.3	0.2	2.6	0.7	2.2	4.4
2	SN012	0.5	-0.1	1.1	0.1	0.7	4.1
3	SN001	-0.2	1.1	2.2	1.2	2.3	1.1
4	SN002	0.3	1.2	1.3	0.8	0.5	4.6
5	SN008	0.7	0.5	1.0	0.1	3.6	5.1
6	SN011	1.1	1.1	1.2	0.7	1.2	4.1
7	SN006	0.6	0.5	1.6	1.2	1.4	2.0
8	SN003	1.1	0.6	1.4	1.0	4.1	3.9
9	SN005	0.4	-0.6	2.0	-0.2	2.3	3.4
10	SN010	0.1	0.4	2.5	0.3	2.8	4.0
11	SN016	-0.2	-0.3	1.0	-0.3	1.1	2.1
12	SN038	2.5	0.5	2.2	-0.1	2.6	4.5
13	SN013	0.2	-0.1	3.7	-0.1	3.1	4.8
14	SN031	0.1	0.2	1.2	0.2	1.8	2.4
15	SN024	-0.6	0.6	2.9	-0.2	2.4	4.0
16	SN023	0.0	-0.2	5.2	0.2	3.8	7.9
17	SN025	-0.4	0.4	5.2	0.1	4.7	9.2
18	SN014	0.4	0.6	1.7	0.2	2.6	4.1
19	SN026	-0.7	0.3	1.4	0.6	2.0	2.5
20	SN015	-0.2	-0.3	1.4	-0.1	1.7	3.1
21	SN037	0.8	-0.4	3.0	0.1	2.6	7.1
22	SN021	0.7	1.0	3.0	0.8	1.9	5.1
23	SN022	0.9	0.8	1.8	0.7	2.5	3.8
24	SN033	0.0	0.8	3.8	0.2	4.3	5.4
25	SN018	1.0	0.9	1.1	0.5	2.9	4.6
26	SN020	1.2	1.2	3.5	0.6	1.2	3.9
27	SN034	0.2	0.4	3.6	-0.1	2.6	4.7
28	SN028	0.0	0.3	3.0	1.1	4.5	5.6
29	SN027	0.4	0.4	4.7	1.0	1.6	4.9
30	SN029	0.3	0.4	2.9	0.1	2.0	4.6
	Mean	0.39	0.41	2.43	0.37	2.42	4.36
	SD	0.63	0.49	1.25	0.45	1.09	1.67

FIG. 14

Degree of Occlusion at Post 3 Hours Wear Time

#	SN#	Code E	Code W	Code X	Code Y	Code Z	Control
1	SN007	91.3	96.2	59.2	88.7	62.5	22.0
2	SN012	90.3	102.7	66.4	97.6	82.7	-21.3
3	SN001	104.5	20.3	-7.5	12.4	8.9	2.8
4	SN002	85.7	35.9	38.9	40.3	79.7	-14.4
5	SN008	89.0	91.3	74.3	97.9	37.3	18.8
6	SN011	81.4	69.1	64.7	73.0	72.6	-13.0
7	SN006	77.8	81.6	23.2	63.3	-18.5	2.2
8	SN003	65.3	87.1	50.9	74.3	-41.4	-63.6
9	SN005	91.5	107.7	64.8	102.9	64.8	45.1
10	SN010	97.7	91.2	46.3	92.6	22.3	4.7
11	SN016	110.8	115.3	22.8	110.0	33.6	31.0
12	SN038	4.8	82.8	22.5	103.9	26.3	-52.9
13	SN013	94.7	101.2	45.0	102.8	24.5	-4.5
14	SN031	94.9	88.8	0.9	92.1	18.4	-3.3
15	SN024	116.7	82.7	13.1	104.1	10.3	-0.6
16	SN023	99.5	103.1	42.2	96.3	49.5	-1.9
17	SN025	106.9	91.9	-3.0	97.1	22.9	-42.4
18	SN014	91.0	71.2	38.0	97.0	20.0	-6.7
19	SN026	128.0	89.4	46.4	72.9	41.2	18.1
20	SN015	107.5	115.3	51.9	106.8	28.4	-50.5
21	SN037	84.3	108.3	29.8	99.0	49.9	-32.8
22	SN021	83.2	73.3	33.9	76.1	55.9	-19.3
23	SN022	77.2	73.1	66.3	67.8	25.5	3.8
24	SN033	99.5	85.5	18.1	94.0	3.0	2.0
25	SN018	75.2	78.7	76.5	86.5	45.3	-3.5
26	SN020	67.6	77.3	17.6	85.5	72.7	-0.3
27	SN034	92.6	87.7	12.3	101.9	46.9	-8.9
28	SN028	99.8	90.5	54.4	79.1	11.5	-19.7
29	SN027	92.3	94.1	15.5	70.8	58.4	-43.9
30	SN029	95.1	93.4	18.7	96.5	58.4	1.2
Mean		89.87	86.22	36.80	86.11	35.78	-8.39
SD		21.07	20.06	23.45	20.97	28.59	24.95

METHODS FOR PHOTODYNAMIC THERAPY

CROSS REFERENCE TO RELATED APPLICATION

This application is a continuation application of U.S. application Ser. No. 17/109,311, filed Dec. 2, 2020, now U.S. Pat. No. 11,135,293, which is a continuation of U.S. application Ser. No. 16/438,702, filed Jun. 12, 2019, now U.S. Pat. No. 11,077,192, which is a continuation of application Ser. No. 15/869,164, filed Jan. 12, 2018, now U.S. Pat. No. 10,357,567, the entire contents of all of which is incorporated herein by reference.

FIELD

The present disclosure relates generally to methods for photodynamic therapy.

BACKGROUND

Photodynamic therapy (PDT), photodynamic diagnosis (PD), or photochemotherapy is generally used to treat and/or diagnose several types of ailments in or near the skin or other tissues, such as those in a body cavity. For example, photodynamic therapy or photodynamic diagnosis may be used for treatment or diagnosis of actinic keratosis of the upper extremities (e.g., the dorsal surface of the hand or forearms), scalp or facial areas of a patient. In addition, such techniques may be used for treatment and diagnosis of other indications (e.g., acne, warts, psoriasis, photo-damaged skin, cancer) and other areas of the patient (e.g., the legs or portions of the arms other than the forearms).

During one form of photodynamic therapy, a patient is first administered a photoactivatable agent or a precursor of a photoactivatable agent that accumulates in the tissue to be treated. The area in which the photoactivatable agent is administered is then exposed to visible light, which causes chemical and/or biological changes in the agent. These changes allow the agent to then selectively locate, destroy, or alter the target tissue while, at the same time, causing at most only mild and reversible damage to other tissues in the treatment area. One example of a precursor of a photoactivatable agent is 5-aminolevulinic acid (“ALA”), which is commonly used in photodynamic therapy of actinic keratosis. As they are used here, the terms ALA or 5-aminolevulinic acid refer to ALA itself, precursors thereof, esters thereof and pharmaceutically acceptable salts of the same. Photosensitization following application of a topical composition (e.g., a topical solution or emulsion) containing ALA occurs through the metabolic conversion of aminolevulinic acid to protoporphyrin IX (PpIX), as discussed in more detail below. PpIX is a photosensitizer which accumulates in the skin.

For photodynamic therapy to be effective, it is desirable to have a power output that can be controlled for intensity and duration, among other factors. Illuminators are typically used to provide the proper uniformity of light for treatment purposes. These devices generally include a light source (e.g., a fluorescent tube or LED), coupling elements that direct, filter or otherwise conduct emitted light so that it arrives at its intended target in a usable form, and a control system that starts and stops the production of light when necessary.

Photodynamic therapy may be carried out using certain compositions, such as ALA, in connection with illuminators

as described above. Such compositions and/or devices are disclosed, for example, in (1) U.S. Pat. No. 5,954,703 to Golub, entitled “Method and apparatus for applying 5-aminolevulinic acid,” issued on Sep. 21, 1999, (2) U.S. Pat. No. 6,223,071 to Lundahl et al., entitled “Illuminator for photodynamic therapy and diagnosis which produces substantially uniform intensity visible light,” issued on Apr. 24, 2001, (3) U.S. patent application Ser. No. 15/371,363 to Boyajian et al., entitled “Method And Apparatus For Applying A Topical Solution,” published on Jun. 8, 2017 as U.S. Pub. No. 2017/0157379, (4) International Application No. PCT/US2016/056572 to Boyajian et al., entitled “Adjustable Illuminator For Photodynamic Therapy And Diagnosis,” published on Apr. 20, 2017 as WO 2017/066270, (5) U.S. patent application Ser. No. 15/292,731 to Boyajian et al., entitled “Adjustable Illuminator For Photodynamic Therapy And Diagnosis,” published on Apr. 20, 2017 as U.S. Pub. No. 2017/0106205, and (6) U.S. patent application Ser. No. 15/487,991 to Boyajian et al., entitled “Adjustable Illuminators And Methods For Photodynamic Therapy And Diagnosis,” published on Aug. 3, 2017 as U.S. Pub. No. 2017/0216616. The entire contents of the foregoing patents and/or patent applications (1)-(6) are incorporated herein by reference for background information and the compositions, devices, processes and techniques relating to photodynamic therapy and diagnosis disclosed therein.

SUMMARY

Through research and experimentation in photodynamic therapeutic techniques, the inventors have found that covering a treatment area with polyethylene (such as low density polyethylene (LDPE)) for a period of time prior to light treatment is particularly effective to minimize transepidermal water loss from the treatment area. Surprisingly, it was found that a polymeric barrier having a degree of occlusion more than 65% (such as LDPE) was superior to other materials such as polyurethane and polyvinylidene chloride (PVdC). The low density polyethylene can be applied to a wide variety of treatment areas, such as the arms, legs, chest, back, portions of the head, and the like, and can be used with drugs other than ALA.

According to one aspect of the disclosure, a method of enhancing penetration of a topical composition of 5-aminolevulinic acid (ALA) into tissue for photodynamic therapy is disclosed. The method includes topically applying ALA to a treatment area to be treated with photodynamic therapy. The method further includes, after the ALA is applied to the treatment area, covering the treatment area with a polymeric barrier have a degree of occlusion of 65% or more.

According to another aspect of the disclosure, a method of enhancing penetration of a topical composition of 5-aminolevulinic acid (ALA) into tissue for photodynamic therapy is disclosed. The method includes topically applying ALA to a treatment area to be treated with photodynamic therapy. The method further includes, after the ALA is applied to the treatment area, covering the treatment area with a low density polyethylene barrier. The treatment area is covered with the low density polyethylene barrier prior to light treatment to minimize transepidermal water loss from the treatment area.

According to still another aspect of the disclosure, a method of photodynamic treatment of the stratum corneum is disclosed. The method includes applying 5-aminolevulinic acid (ALA) to a lesion on the stratum corneum and reducing evaporation from a portion of the stratum corneum including an area where the lesion is present. The method

further includes heating the area where the lesion is present before or during illumination of the area where the lesion is present.

According to a further aspect of the disclosure, a method of using 5-aminolevulinic acid (ALA) and a low density polyethylene barrier is disclosed. The method includes contacting a treatment site with a composition comprising the ALA so as to wet the treatment site, and, following wetting of the treatment site, covering the wetted treatment site with the low density polyethylene barrier.

According to an additional aspect of the disclosure, a method of enhancing penetration of a topical composition of 5-aminolevulinic acid (ALA) HCl into tissue for photodynamic therapy is disclosed. The method includes topically applying the composition to a treatment area to be treated with photodynamic therapy. The method further includes, after the composition is applied to the treatment area, covering the treatment area with a low density polyethylene barrier prior to light treatment to minimize transepidermal water loss from the treatment area. The composition exhibits a mean plasma concentration (C_{max}) value of ALA less than about 110 ng/mL when the ALA HCl is applied in an amount of 354 mg.

BRIEF DESCRIPTION OF THE DRAWINGS

The details of one or more embodiments are set forth in the accompanying drawings and the description below. Other features, aspects, and advantages will become apparent from the description, the drawings, and the claims. In the drawings, like reference numerals are used throughout the various views to designate like components. The drawings are briefly described below.

FIGS. 1A-1B show top views of a main body of an illuminator according to an exemplary embodiment.

FIGS. 2A-2B show perspective views of the main body of the illuminator of FIGS. 1A-1B.

FIG. 3 shows a perspective view of the illuminator having the main body of FIGS. 1A-1B mounted to a stand.

FIG. 4 shows a representative region to be treated in accordance with an exemplary embodiment.

FIG. 5 depicts evaporative water loss rates for a plurality of materials, in accordance with at least one embodiment.

FIG. 6 depicts the degree of occlusion for a plurality of materials, in accordance with at least one embodiment.

FIG. 7 depicts evaporative water loss rates for a plurality of materials, in accordance with at least one embodiment.

FIG. 8 depicts the degree of occlusion for a plurality of materials, in accordance with at least one embodiment.

FIG. 9 is a table containing baseline water loss data for the materials referred to in FIGS. 5-6.

FIG. 10 is a table containing water loss data following three hours of wear time for the materials referred to in FIGS. 5-6.

FIG. 11 is a table containing occlusion data for the materials referred to in FIGS. 5-6.

FIG. 12 is a table containing baseline water loss data for the materials referred to in FIGS. 7-8.

FIG. 13 is a table containing water loss data following three hours of wear time for the materials referred to in FIGS. 7-8.

FIG. 14 is a table containing occlusion data for the materials referred to in FIGS. 7-8.

It will be recognized that some or all of the figures are schematic representations for purposes of illustration. The figures are provided for the purpose of illustrating one or

more embodiments with the explicit understanding that they will not be used to limit the scope or the meaning of the claims.

DETAILED DESCRIPTION

Various embodiments are described hereinafter. It should be noted that the specific embodiments are not intended as an exhaustive description or as a limitation to the broader aspects discussed herein. One aspect described in conjunction with a particular embodiment is not necessarily limited to that embodiment and can be practiced with any other embodiment(s).

The following terms are used throughout and are as defined below.

As used herein and in the appended claims, singular articles such as “a” and “an” and “the” and similar references in the context of describing the elements (especially in the context of the following claims) are to be construed to cover both the singular and the plural, unless otherwise indicated herein or clearly contradicted by context. Recitation of ranges of values herein are merely intended to serve as a shorthand method of referring individually to each separate value falling within the range, unless otherwise indicated herein, and each separate value is incorporated into the specification as if it were individually recited herein. All methods described herein can be performed in any suitable order unless otherwise indicated herein or otherwise clearly contradicted by context. The use of any and all examples, or exemplary language (e.g., “such as”) provided herein, is intended merely to better illustrate the embodiments and does not pose a limitation on the scope of the claims unless otherwise stated. No language in the specification should be construed as indicating any non-claimed element as essential.

The embodiments, illustratively described herein may suitably be practiced in the absence of any element or elements, limitation or limitations, not specifically disclosed herein. Thus, for example, the terms “comprising,” “including,” “containing,” etc. shall be read expansively and without limitation. Additionally, the terms and expressions employed herein have been used as terms of description and not of limitation, and there is no intention in the use of such terms and expressions of excluding any equivalents of the features shown and described or portions thereof, but it is recognized that various modifications are possible within the scope of the claimed technology. Additionally, the phrase “consisting essentially of” will be understood to include those elements specifically recited and those additional elements that do not materially affect the basic and novel characteristics of the claimed technology. The expression “comprising” means “including, but not limited to.” Thus, other non-mentioned substances, additives, devices or steps may be present. Unless otherwise specified, “a” or “an” means one or more.

Unless otherwise indicated, all numbers expressing quantities of properties, parameters, conditions, and so forth, used in the specification and claims are to be understood as being modified in all instances by the term “about.” Accordingly, unless indicated to the contrary, the numerical parameters set forth in the following specification and attached claims are approximations. Any numerical parameter should at least be construed in light of the number reported significant digits and by applying ordinary rounding techniques. The term “about” when used before a numerical designation,

e.g., temperature, time, amount, and concentration including range, indicates approximations which may vary by (+) or (-) 10%, 5% or 1%.

As will be understood by one of skill in the art, for any and all purposes, particularly in terms of providing a written description, all ranges disclosed herein also encompass any and all possible subranges and combinations of subranges thereof. Any listed range can be easily recognized as sufficiently describing and enabling the same range being broken down into at least equal halves, thirds, quarters, fifths, tenths, etc. As a non-limiting example, each range discussed herein can be readily broken down into a lower third, middle third and upper third, etc. As will also be understood by one skilled in the art all language such as "up to," "at least," "greater than," "less than," and the like include the number recited and refer to ranges which can be subsequently broken down into subranges as discussed above. Finally, as will be understood by one skilled in the art, a range includes each individual member.

Exemplary Illuminator

FIGS. 1A-1B and 2A-2B illustrate one embodiment of a configurable illuminator as may be used in accordance with the present disclosure. The illuminator includes a main body **100**, which preferably has a plurality of individual panels (e.g., panels **10a-10e**, each of which are connected in a rotatable manner via nested hinges **50**). As shown in FIGS. 2A-2B, on at least one side of a panel, a tab **23** may extend out from both the top and bottom of the panel. The tabs **23** are configured such that a side of an adjacent panel may be received between the tabs **23**, as shown in FIG. 2A, and the hinges **50** are between the tabs **23**. Each panel contains an array of light emitting diodes (LED) **60**. The number of individual LEDs arranged in a given array is not particularly limited. Alternatively, other types of light sources may be used, such as fluorescent or halogen lamps. The LED arrays **60** emit light at an appropriate wavelength according to the intended treatment or to activate the particular photoactivatable agent used in treatment or diagnosis.

In at least one embodiment, when ALA is used as a precursor of a photoactivatable agent for the treatment of actinic keratosis, the LED arrays **60** preferably emit blue light having wavelengths at or above 400 nanometers (nm), for example, about 430 nm, about 420 nm or, for example, 417 nm. However, the LED arrays **60** may also emit visible light in other ranges of the spectrum, such as in the green and/or red ranges between 400 and 700 nm, for example, about 625 nm to 640 nm or, for example, 635 nm. For example, the LED arrays **60** may also emit light having wavelengths of 510 nm, 540 nm, 575 nm, 630 nm, or 635 nm. In addition, the LED arrays **60** may be configured to emit light continuously or the LED arrays **60** may be configured to flash the diodes on and off based on a predetermined interval. Furthermore, the LED arrays **60** may be configured such that only one wavelength of light (e.g., blue) is emitted. Alternatively, the LED arrays **60** may be configured such that two or more wavelengths of light are emitted from the arrays. For example, the LED arrays **60** may be configured to alternately emit blue light and red light for treatment purposes. In one embodiment, the LED arrays may also emit red light having wavelengths of 570 to 670 nm.

In one embodiment of the present disclosure, blue light having a wavelength of approximately 417 nm is applied at an intensity of 10 mW/cm² for 1000 seconds to provide a dose of 10 J/cm². However, the intensity may be increased (for example, doubled) to reduce the treatment time. For example, the intensity may be increased so as to reduce the

treatment time by about one-half. In other embodiments, red light (such as red light generated by light emitting diodes (LEDs) at, for example, 635 nm) may be used. The red light can provide a dose of, for example, 10 to 75 J/cm² (such as 37 J/cm²), e.g., within 10 minutes.

The ALA can be applied using an applicator as described below, using, for example, a 20% solution of ALA, or can be applied by other means such as glove protected fingers or a spatula. The ALA can be applied in, for example, liquid or gel form and can be applied beyond the lesions to be treated. In certain applications, materials other than low density polyethylene may be used as long as they have a degree of occlusion of 65% or more. In certain applications, certain materials may be used as long as they have a degree of occlusion of 75% or more.

Referring again to the exemplary illuminator shown in FIGS. 1A-1B, the main body **100** of the illuminator may include a mounting head **40**. The mounting head **40** may allow for the main body **100** to be mounted to a movable stand **80**, which is shown in FIG. 3, to allow a user to easily move the main body **100** to the appropriate treatment position. The stand **80** includes a base **81** and a vertical pillar **82**. The base **81** may further include wheels **87** at its bottom in order to allow the user to horizontally move the illuminator to an appropriate position. The wheels **87** may include locks, such that the stand **80** is prevented from further horizontal movement once positioned. In addition, the vertical pillar **82** may be attached to the base **81** at a pivot point **83**.

At a top end, the vertical pillar **82** includes a connecting arm **85**, which may serve as a mounting structure for the main body **100**. The connecting arm **85** includes a hinge point **86** such that the main body **100** can be moved vertically relative to the stand **80**. The stand **80** may also include a stabilization arm **84**. Once the stand **80** and main body **100** is positioned, the stabilization arm **84** may be attached to the main body **100** to prevent unwanted movement of the main body **100** during treatment. As further shown in FIG. 3, a controller and power supply **90** is mounted to the stand **80** in order to supply electrical power to the main body **100** and allow the user to control the main body **100** for treatment purposes. Alternatively, the controller and power supply **90** may be directly mounted to the main body **100**. In order to provide a cooling system for the LED arrays **60**, one or more fans **70** may be mounted onto each of the panels, as shown in FIG. 3.

The controller and power supply **90** may be also connected to the panels to regulate power to the light source to achieve a desired uniformity and intensity for the target treatment. The control unit may be implemented as hardware, software, or a combination of both, such as a memory device storing a computer program and a processor to execute the program. Alternatively, each panel may have a dedicated control unit to regulate power to the individual LED array on a given panel to allow for fine-tuning of the illuminator, which may further enhance uniformity and increase efficiency. The LED arrays **60** may be individually configured to increase the intensity of light emitted from certain diodes to achieve particular illumination effects.

The illuminator may further include a timer included in the controller and power supply **90**, which can indicate to the user the appropriate length of exposure time for the particular treatment. The illuminator may also be programmed with pre-stored light dosing parameters to allow the user to select a desired treatment type. The pre-stored parameters may include, for example, pre-stored settings for exposure time, light intensity, and outputted wavelength. Based on the

selected treatment, the illuminator is automatically configured to provide the correct lighting dosage by being supplied with the appropriate power output to achieve the required uniformity for the treatment.

Alternatively, the illuminator can be provided with sensors that detect the size of the treatment area positioned in front of the illuminator. The sensors then determine the correct light dosing parameters based on the sensed treatment area. The sensors may detect the adjusted position of the illuminator manually set by the user. The detected position of the illuminator may then be used to indicate the intended treatment area. Appropriate light dosing parameters for the specific treatment area may then be provided based on the detected position set by the user.

Adjustable illuminators as described above allow for an infinite amount of configurations that can be adapted for the targeted treatment area. The configurations may range from a flat-plane emitter (as shown in FIGS. 1B and 2B) to a substantially U-shaped configuration (as shown in FIGS. 1A and 2A). Not only can the adjustable illuminator effectively deliver a uniform light intensity to surfaces such as the face or scalp, but the adjustable illuminator can also provide a device that can easily be configured to treat other portions of a patient's body, in particular, those having smaller curved surfaces, such as the arms and legs, and in particular, the upper extremities. Moreover, the adjustable illuminator may also be easily positioned to deliver a uniform light intensity to larger treatment areas, such as the back or chest.

The illuminator may irradiate the lesions with a uniform intensity red light for a prescribed period. In certain embodiments, the illuminator irradiates the lesions with a uniform intensity blue light for a first prescribed period and then irradiates the lesions with a uniform intensity red light for a second prescribed period. For example, in some embodiments, the illuminator is configured to irradiate the lesions with a uniform intensity blue light (e.g., 417 nm) at a low intensity (e.g., about 0.1 J/cm² to about 2 J/cm²) to photobleach, for example, protoporphyrin IX (PpIX) present at the surface of the patient's skin, and irradiate the lesions with a uniform intensity red light (e.g., 635 nm) at a high intensity (e.g., about 30 J/cm² to about 150 J/cm²) to activate PpIX present at deeper layers of the patient's skin, thus avoiding potential damage to the upper layers of the patient's skin.

Furthermore, since the total light dose (J/cm²) is equal to irradiance (mW/cm²) multiplied by time (sec), an additional parameter to be controlled for delivery of the correct treatment light dose is exposure time. This may be accomplished by the timer described above, which can control the electrical power supplied to the LED arrays appropriately, and which can be set by the physician. Data has shown that 10 J/cm² delivered from a source with an irradiance density of 10 mW/cm², or an irradiance density of about 9.3 to about 10.7 mW/cm², produces clinically acceptable results for desired treatment areas (e.g., face, scalp, extremities). An adjustable illuminator may deliver an irradiance density of 20 mW/cm² for an exposure time of 500 seconds (8 min. 20 sec) to deliver a clinically acceptable light dose of 10 J/cm². In certain embodiments, a lower intensity may be used with a longer exposure time (e.g., 1,000 seconds of exposure time for a light dose of 10 J/cm²). Alternatively, the adjustable illuminator may include higher power ranges, such as 30 mW/cm², over an exposure time resulting in a light dose of 10 J/cm². A selected light dose may also be administered by additionally or alternatively varying the irradiance density over treatment time.

In at least one embodiment, a heating element (a heat source) may be provided. The heat source may be used to

heat the region to be treated. According to one embodiment, a method of treatment includes warming up an illuminator so as to cause heat to be emitted from the illuminator, and exposing a treatment site to the illuminator. The heat accelerates the conversion of the ALA to porphyrin (e.g., photosensitive porphyrin or proto porphyrin). The relationship between temperature exposure and ALA conversion is non-linear, and the enzymatic pathways responsible for the conversion are highly sensitive to temperature. In at least one embodiment, increasing the temperature by approximately 2° C. may approximately double the rate of production of protoporphyrin IX (PpIX), for example.

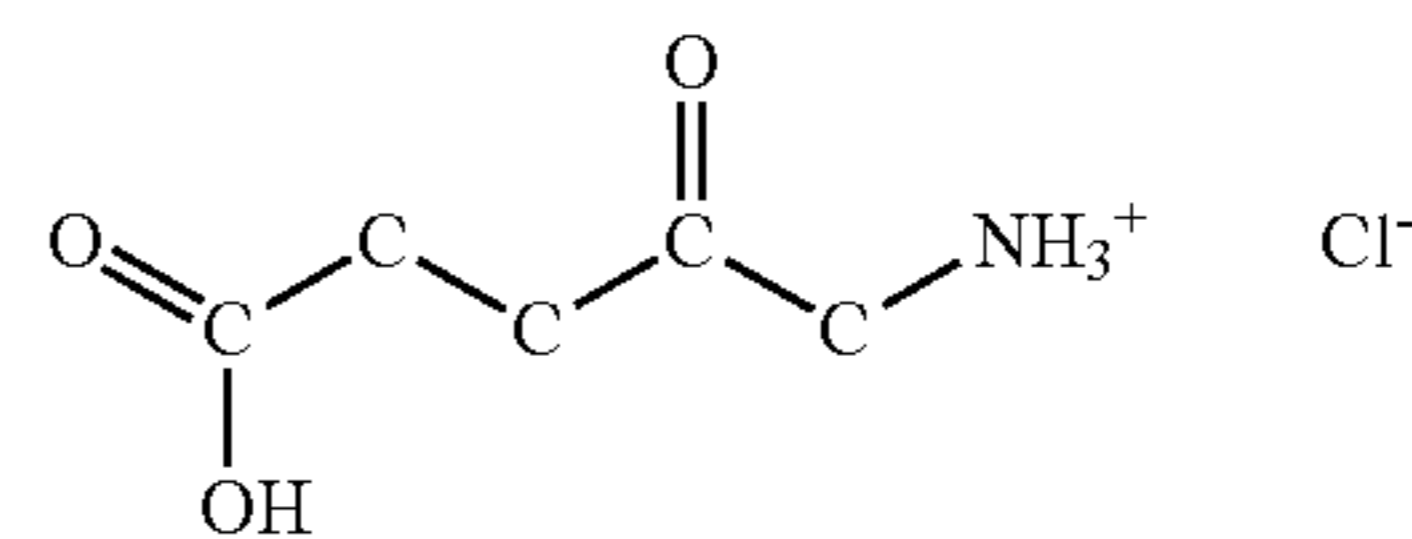
The heat may be applied before or during illumination with the illuminator. For example, first, the ALA may be applied. Next, the heating element may be activated, to apply heat to the patient's skin for a first treatment period for a thermal soak, which may be 20-30 minutes, for example. During the heating, the treatment site may or may not be occluded. In other words, the treatment site may be heated while being occluded.

Following the first treatment period, light may be applied for a second treatment period, e.g., about 8-15 minutes. In at least one embodiment, the heat source may be an infrared quartz heater. In at least one embodiment, the heat source may comprise frame mounted resistance tape heaters or a plurality of heaters, including at least one selected from the group including IR LEDs, resistance cartridge heaters, positive temperature coefficient heaters, or IR quartz heaters, as mentioned above. The heat may be deliberately generated and directed towards the area to be treated, as opposed to ambient heat in the clinical setting or byproduct heat from one or more operating mechanisms of the illuminator.

Administration of ALA

As indicated above, during photodynamic therapy, a total light dose is received by a patient over the course of treatment. The total light dose, in terms of J/cm², may be measured based on emitted irradiance (mW/cm²) over time (in seconds). One example of a treatment method for precancerous lesions, such as actinic keratosis, by photodynamic therapy utilizing an adjustable illuminator described above in conjunction with ALA will now be described.

Essentially anhydrous ALA is admixed with a liquid diluent just prior to its use. The anhydrous ALA may be, for example, the hydrochloride salt of aminolevulinic acid (ALA), an endogenous 5-carbon aminoketone. The chemical name for ALA HCl, as employed in the embodiments disclosed herein, is 5-amino-4-oxopentanoic acid hydrochloride (molecular weight=167.59). ALA HCl is highly soluble in water. The structural formula of ALA HCl is represented below:



In at least one embodiment, the ALA is contained in powdered form inside a first ampule. In the first ampule, the amount of ALA as a dry solid may be between 300-400 mg. In at least one embodiment, the amount of ALA HCl is 354 mg. A second ampule contains a solution vehicle. The second ampule contains 1.5 mL of the solution vehicle. The solution vehicle comprises alcohol (i.e., alcohol as defined

by the United States Pharmacopeia Convention) (ethanol content=48% v/v), water, laureth-4, isopropyl alcohol, and polyethylene glycol.

The first and second ampules are contained inside a plastic applicator. The first and second ampules may be crushed, e.g., by applying finger pressure, or inside a device configured to exert pressure on the ampule. Once the ampules are crushed, the ALA formerly contained in the first ampule contacts the solution formerly contained in the second ampule, and dissolves in the solution vehicle. The applicator in which the ampules were provided may be shaken so as to disperse and dissolve the powdered ALA in the solution vehicle. Once combined, the resulting solution is applied to the patient within 2 hours of preparation.

In some embodiments, the ALA may be provided in a composition such as a ready-to-use solution or a reconstituted powder for solution, gel, cream or lotion formulation. In another embodiment, the composition comprises 5-aminolevulinic acid hydrochloride in an amount of about 10% to about 70% w/w based on the total weight of the composition, preferably from about 20% to about 50% w/w based on the total weight of the composition, more preferably from about 30% to about 40% w/w based on the total weight of the composition.

In one embodiment, ALA may be applied in a topical composition with a concentration of 20%. The ALA admixture is topically applied to the lesions using a point applicator to control dispersion of the ALA admixture, in at least one embodiment, so as to achieve a substantially uniform wetting of the lesion surface with the ALA by contacting the ALA with the lesion surface. The term “substantial,” or “substantially” as used herein, may refer to any value which lies within the range as defined by a variation of up to ± 15 from the average value. However, in other embodiments, the ALA may be applied digitally (i.e., by first disposing the ALA on the gloved fingertips of a practitioner, who then dabs the ALA on the region to be treated), or with a tool such as a spatula.

Occlusion with Barrier

Following application of the ALA to the region to be treated (i.e., the lesion), the region to be treated may be occluded with a polymer barrier. For example, as shown in FIG. 3, a polymer barrier **200** is wrapped around a region to be treated **300**. While the exemplary embodiment shown in FIG. 3 depicts the barrier **200** as encircling the region **300**, it should be understood that in certain embodiments, the barrier **200** may only occlude a portion of the region **300**. Further, while barrier **200** is depicted as substantially cylindrical (e.g., so as to form a sleeve around region **300**), the barrier **200** may have a variety of shapes.

The barrier **200** is shown with a clearance from the region **300** purely for ease of illustration in FIGS. 3 and 4. In at least one embodiment, however, the barrier **200** clings or adheres to the region **300** such that there is effectively no clearance between the barrier **200** and the region **300**. The polyethylene barrier may have electrostatic properties that provide an adhesive clinging effect such that the barrier tends to stay close to the surface of the skin, even for prolonged periods. Such an effect may be particularly enhanced when the skin is wetted with the topical solution, i.e., when the treatment site is first wetted with the topical solution, and the barrier **200** is then applied directly on the wetted treatment site.

Experimental results confirmed that employing low density polyethylene (LDPE) for barrier **200** resulted in lower water loss rates and a superior degree of occlusion. In

particular, embodiments with low density polyethylene barriers **200** were particularly effective for photodynamic therapy.

FIG. 5 depicts evaporative water loss rates for a plurality of materials A-E as summarized below in Table 1. The LDPE barriers were found to be especially conducive to retaining water and allowing for greater penetration of the ALA into the region to be treated.

TABLE 1

Barrier Materials A-E			
Material Code	Name	Distributor or Manufacturer	Material Description
A	Tegaderm™, Style 1629	3M	Polyurethane
B	Glad® Press'n Seal®	The Glad Products Company	LDPE
C	Glad® Cling Wrap	The Glad Products Company	LDPE
D	Stretch-Tite®	Polyvinyl Films, Inc.	Polyvinylidene chloride (PVdC)
E	Saran™ Premium Wrap	SC Johnson	LDPE

The measured water loss rates shown in FIG. 5 (and FIG. 7, discussed below) are transepidermal water loss rates measured on the dorsal forearms, measured both before and after the barrier **200** had been worn for 3 hours. The baseline water loss was measured for approximately 30 subjects, after a minimum 25-minute acclimation period in a controlled environment with less than 50% relative humidity and a temperature between 19-22 deg. Celsius. Such measurements correspond to the bar plots labeled “pre” in FIGS. 5 and 7. The subjects had mild to moderate photodamage on their dorsal forearms. The measurements were made using a calibrated RG1 Evaporimeter System (made by cyberDERM, Inc. of Broomall, Pa.) with DermaLab® transepidermal water loss probes (made by Cortex Technology of Hadsund, Denmark).

A vapor pressure gradient estimation method was used. The probes measure the temperature and relative humidity at fixed points along the skin, allowing derivation of a value corresponding to evaporative water loss in $\text{gm/m}^2 \text{ hr}$. Sampling was performed at 4 inputs/second. The baseline measurements indicate the barrier properties of the stratum corneum of each subject, prior to applying barrier **200** to the stratum corneum. The measurements taken 3 hours after application of the barrier **200** are indicative of the barrier properties of the materials shown in Tables 1-2. Such measurements correspond to the bar plots labeled “post” in FIGS. 5 and 7. Each barrier **200** was cut so as to cover a test site area of 5 cm by 5 cm prior to application. The barrier **200** was secured with hypoallergenic medical tape for the purpose of testing. An area of the subjects' skin without the barrier **200** was measured as a control.

FIG. 6 depicts degrees of occlusion for a plurality of materials in accordance with at least one embodiment. More specifically, FIG. 6 depicts the degree of occlusion for the materials shown in FIG. 5 and summarized above in Table 1. The degree of occlusion corresponds to the decrease in evaporative water loss rate when the subject wore the barrier **200** as compared to the baseline evaporative water loss rate. As indicated in FIG. 6, barrier material E, for example, blocked approximately 85% or more of the water vapor from evaporating from the skin surface. In one embodiment, a polymeric barrier having a degree of occlusion more than 65% is particularly effective for photodynamic therapy. In

one embodiment, a polymeric barrier having a degree of occlusion more than 75% is particularly effective for photodynamic therapy. Greater occlusivity of LDPE materials such as material E enhances the penetration of ALA into the tissue by minimizing transepidermal water loss from the treatment area. The tissue may be skin, in particular, the stratum corneum, or other tissue of a human subject.

Similar to material E, materials B and C blocked approximately 75% of the water vapor from evaporating from the skin surface. Materials A and D, on the other hand, appeared to be semi-occlusive barriers.

FIG. 7 depicts evaporative water loss rates for a plurality of materials in accordance with at least one embodiment. More specifically, FIG. 7 depicts evaporative water loss rates for a plurality of materials W-Z and E as summarized below in Table 2. Barrier material E was the same material as shown in Table 1 and discussed above. Materials W-Z included LDPE and polyvinylidene chloride.

TABLE 2

Barrier Materials W-Z and E			
Material Code	Name	Distributor or Manufacturer	Material Description
W	Best-Yet Clear Plastic Wrap	C&S Wholesale Grocers, Inc.	LDPE
X	Boardwalk® PVC Food Wrap Film, BWK7204	Boardwalk	PVdC
Y	Shurfine® Strong and Stretchy® Plastic Wrap	Western Family Foods, Inc.	LDPE
Z	Premium Plastic Wrap	Foodhold USA, LLC	PVdC
E	Saran™ Premium Wrap	SC Johnson	LDPE

FIG. 8 depicts degrees of occlusion for a plurality of materials in accordance with at least one embodiment. More specifically, FIG. 8 depicts the degree of occlusion for the materials shown in FIG. 7 and summarized above in Table 2. As seen in FIG. 8, materials E, W, and Y were significantly more occlusive than materials X and Z. Materials X and Z block only approximately 35% of water vapor from evaporating and are thus semi-occlusive in nature. Material E, due to its flexible nature, easily wraps around the treatment site, which may promote water retention.

FIG. 9 is a table containing baseline water loss data for the materials referred to in FIGS. 5-6. In particular, FIG. 9 provides the baseline measurements for each subject for each material A-E shown in Table 1, including mean and standard deviation values. FIG. 10 is a table containing water loss data following three hours of wear time for the materials referred to in FIGS. 5-6. FIG. 11 is a table containing occlusion data for the materials referred to in FIGS. 5-6. FIG. 12 is a table containing baseline water loss data for the materials referred to in FIGS. 7-8. FIG. 13 is a table containing water loss data following three hours of wear time for the materials referred to in FIGS. 7-8. FIG. 14 is a table containing occlusion data for the materials referred to in FIGS. 7-8.

As discussed above, the barrier 200 is used to occlude at least a portion of the region to be treated, e.g., all or part of the dorsal surface of the hand. In some embodiments, and particularly for larger treatment areas, such as the forearm, an additional structure may be provided to secure the barrier 200 in place. The low density polyethylene wrap may be secured in place with a dressing 210, shown in FIG. 4. In one embodiment, the dressing 210 is a surgical netting such as Surgilast® Tubular Elastic Dressing Retainer made by Derma Sciences Inc. of Plainsboro, N.J. The dressing 210

may be a tubular elastic stretch net designed to serve as a secondary dressing, which applies a relatively light pressure to keep barrier 200 securely in place without adhesive tape. That is, the secondary dressing 210 may exert slight compressive pressure on the barrier 200. The dressing 210 may be a sleeve which fits over and around barrier 200. In some embodiments, the secondary dressing and/or tape may be applied. Following application of the ALA and occlusion, treatment may be carried out in accordance with the exemplary implementations described below.

Treatment Protocols

Once the ALA is applied to the upper extremities, the upper extremities may be occluded for no more than three hours prior to light treatment. For example, the extremities may be occluded for 2-3 hours. As indicated above, the ALA is a porphyrin precursor which, when used as part of photodynamic therapy, may treat various conditions including minimally to moderately thick actinic keratoses of the face, scalp or the upper extremities. Accordingly, in at least one embodiment, one or more of a portion of the face, a portion or all of the scalp, or a portion or all of one or more of the upper extremities may be covered in an occlusive barrier.

Where the ALA is used to treat lesions of the face and scalp without the application of an occlusive barrier, following application of the ALA, formation of photosensitive porphyrin and photosensitization of the treated lesions occurs after 14-18 hours. Between 14 and 18 hours after administration of the ALA, the lesions are irradiated by an illuminator. The illuminator may, for example, irradiate the lesions with a uniform intensity blue light for a prescribed period. According to a preferred treatment, the visible light has a nominal wavelength of 417 ± 5 nm.

The time period for illumination where the ALA is used to treat a lesion on an upper extremity can be significantly shorter when performed with the application of an occlusive barrier than for the face or scalp sites. The time period is approximately 3 hours between (1) application of ALA to the upper extremities and occlusion, and (2) the illumination of the upper extremities. If the occlusion time exceeds three hours for some treatment areas, then the skin where the ALA is applied may experience irritation. Excessive irritation may be marked by the presence of itching spots, wheals, flares, or other indicia, including symptoms persisting after the treatment session has ended. In particular, excessive irritation is marked by adverse cutaneous events such as scaling, crusting, ulceration, rashes, scabbing, tenderness and itching, for example. Three hours represents the nominal maximum time under which the upper extremity should be occluded following application of ALA, so as to avoid such excessive irritation while maintaining therapeutic efficacy. Therapeutic efficacy is the clearance of actinic keratosis lesion 12 weeks after PDT. The time period between the application of ALA to other body parts (other than the face, scalp and upper extremities) and illumination may be 3 hours, in some embodiments.

Once the occlusive barrier 200 is removed, light treatment as described above may be performed, e.g., application of red and/or blue light for a light dose of 10 J/cm^2 . For example, once the barrier 200 is removed within 3 hours of being applied, blue light may be applied to the exposed treatment area to deliver a light dose of 10 J/cm^2 , or red light may be applied for a 10 J/cm^2 to 75 J/cm^2 light dose. In some embodiments, the light may be delivered while the treatment site is still occluded. In some embodiments, light and heat may be delivered while the treatment site is still occluded.

To treat facial lesions, an illuminator as described above may be positioned such that the region to be treated is between 2 to 4 inches from a surface of the illuminator, with the patient's nose not less than 2 inches from the illuminator surface, and the forehead and cheeks no more than 4 inches from the surface. The sides of the patient's face and the patient's ears should be no closer than 2 inches from the illuminator surface.

To treat scalp lesions, an illuminator as described above may be positioned such that the region to be treated is between 2 to 4 inches from a surface of the illuminator, with the patient's scalp not less than 2 inches from the illuminator surface, and no more than 4 inches from the surface. The sides of the patient's face and the patient's ears should be no closer than 2 inches from the illuminator surface.

To treat lesions on the upper extremities, such as the dorsal surface of the hand or the forearms, an illuminator as described above may be positioned such that the region to be treated is between 2 to 4 inches from a surface of the illuminator. Equipment (e.g., a table) may be used to support the upper extremity during light treatment so as to enhance the patient's comfort and stabilize the region to be treated.

Two open-label, pharmacokinetic studies were carried out to evaluate the potential for systemic exposure of ALA and ALA and protoporphyrin IX (PpIX) when applied topically under occlusion, in a maximal use setting in patients with multiple actinic keratoses (AK) lesions on the upper extremities. In accordance with at least one embodiment, a 20% w/w topical composition of 5-aminolevulinic acid (ALA) was directly applied topically via an applicator to the upper extremities of the patients followed by covering with an occlusive, polyethylene film for a 3 hour incubation period. Light treatment was administered after the incubation period. Each subject received 10 J/cm² of visible blue light delivered at 10 mW/cm².

In the first of the two studies, a total of 29 participants were enrolled. The participants were males and non-pregnant females, aged 18 years or older. Each eligible subject had at least six Grade 1 or Grade 2 AK lesions on one upper extremity treatment area and at least 12 Grade 1 or Grade 2 AK lesions on the other upper extremity treatment area. The subjects received one treatment and were followed until week four after treatment. The treatment area, designated at baseline for the duration of the study, was the extensor surface of both distal upper extremities, as defined in the protocol (i.e., the dorsal hands/forearms). In the second of the two studies, a total of 14 participants were enrolled. Males and non-pregnant females, aged 18 years or older, with at least six Grade 1 or Grade 2 AK lesions on one upper extremity treatment area and at least 12 Grade 1 or Grade 2 AK lesions on the other upper extremity treatment area, were eligible for the study.

The topical application of the ALA to the upper extremities resulted in lower systemic exposure to ALA and PpIX than intravenous and oral dosing. The method according to at least one embodiment includes application of up to two topical solution compositions each containing about 354 mg ALA. The dosing using the topical solution was compared to intravenous and oral dosing in an amount of about 100 mg ALA. As indicated above, strength of the ALA was about 20% by weight. The topical dosing was observed to result in a mean plasma concentration (C_{max}) value of ALA of less than about 110 ng/mL. The term " C_{max} " as used herein refers to maximum observed plasma concentrations based on actual values measured following study medication application.

In particular, following topical applications, the geometric mean maximum plasma concentration was about 98 ng/mL at a median of 2 hours following application, with the geometric mean area-under-the-curve (AUC_t) of 577 ng*h/mL, with variability from about 94% to about 170%. Following a baseline correction, the ALA geometric mean maximum plasma concentration was 80 ng/mL at a median of 2 hours, with a geometric mean AUC_t of 282 ng*h/mL. In an embodiment, the topical solution, when applied in a strength of about 20% by weight, exhibits a geometric mean area under curve (AUC_t) value of ALA less than about 350 ng*hr/mL. The term " AUC_t " as used herein, refers to the area under the plasma concentration-time curve up to the last quantifiable/non-negative plasma concentration.

In another experiment, following topical applications, the geometric mean maximum plasma concentration was about 61 ng/mL at a median of 2 hours following application, with the geometric mean AUC_t of 727 ng*h/mL, with variability from about 30% to about 152%. Following a baseline correction, the ALA geometric mean maximum plasma concentration was 39 ng/mL at a median of 2 hours, and a geometric mean AUC_t of 182 ng*h/mL. The estimated bioavailability following topical application of 354 mg ALA with occlusion was about 1.0%. In one embodiment, the systemic bioavailability following topical application of 354 mg ALA HCl is less than about 5%. The term "bioavailability" as used herein refers to the rate and extent of absorption and is determined by AUC_t and C_{max} values.

In accordance with at least one embodiment, a method of photodynamic therapy was carried out to treat lesions on the upper extremities in a multi-center randomized, parallel-group, evaluator-blinded and vehicle-controlled study of 269 patients with 4-15 mild to moderate actinic keratoses. The actinic keratoses were present on the upper extremities, more specifically, on the dorsal surface of the hands and/or the forearm area between the elbow and the base of the fingers. Subjects ranged from 45 to 90 years of age (mean 68 years) and 90% had Fitzpatrick Skin Type I, II or III. Subjects were randomized to treatment in a 1:1 ratio. ALA was applied to lesions on the dorsal surface of one hand or the forearm for each subject, and the dorsal surface of the hand or the forearm was then occluded with low density polyethylene barrier for three hours. Following removal of the low density polyethylene barrier, a 10 J/cm² dose of blue light was delivered at 10 mW/cm², with treatment repeated after 8 weeks if any lesion(s) remained in the treatment area.

Complete clearance (i.e., resolution of the actinic keratoses) was achieved by 31% of the subjects (that is, 42 out of 135 subjects) receiving ALA. Complete clearance was achieved at twelve weeks after initial treatment, as compared to 13% of subjects (that is, 17 out of 134 subjects) receiving only the solution vehicle (without the ALA). Of the subjects who achieved complete clearance at twelve weeks, a twelve-month follow-up evaluation was performed, which indicated that those subjects had a recurrence rate of 58%. The recurrence rate corresponds to the percentage of subjects with at least one recurrent lesion during the 12 month follow up period following the evaluation at twelve weeks who had previously achieved complete clearance at twelve weeks following treatment.

The present disclosure thus provides a method for photodynamically treating a surface of a patient, and occluding the patient's skin as part of treatment. The patient may be illuminated to treat actinic keratosis, acne, photo-damaged skin, cancer, warts, psoriasis, or other dermatological conditions.

While this specification contains certain specific implementation details, these should not be construed as limitations on the scope of what may be claimed, but rather as descriptions of features specific to particular implementations. Certain features described in this specification in the context of separate implementations can also be implemented in combination in a single implementation. Conversely, various features described in the context of a single implementation can also be implemented in multiple implementations separately or in any suitable subcombination. Moreover, although features may be described above as acting in certain combinations and even initially claimed as such, one or more features from a claimed combination can in some cases be excised from the combination, and the claimed combination may be directed to a subcombination or variation of a subcombination.

It is important to note that the construction and arrangement of the illuminator system shown in the various example implementations are illustrative only and not restrictive in character. All changes and modifications that come within the spirit and/or scope of the described implementations are desired to be protected. It should be understood that some features may not be necessary and implementations lacking the various features may be contemplated as within the scope of the disclosure, the scope being defined by the claims that follow. When the language "a portion" is used the item can include a portion and/or the entire item unless specifically stated to the contrary.

Additional advantages and modifications will readily occur to those skilled in the art. Therefore, the invention in its broader aspects is not limited to the specific details and representative devices and methods, shown and described herein. Accordingly, various modifications may be made without departing from the spirit and scope of the general inventive concept as defined by the appended claims and their equivalents.

What is claimed is:

1. A method of enhancing penetration of a topical composition of 5-aminolevulinic acid (ALA) into tissue for photodynamic therapy, the method comprising:

topically applying ALA to a treatment area to be treated with photodynamic therapy;

after the ALA is applied to the treatment area, covering the treatment area with a low density polyethylene barrier prior to light treatment such that a degree of occlusion of the treatment area of at least 65% is provided; and

removing the low density polyethylene barrier after 3 hours and then applying light to the treatment area.

2. The method according to claim 1, comprising covering the treatment area with the low density polyethylene barrier prior to light treatment such that a degree of occlusion of the treatment area of at least 75% is provided.

3. The method according to claim 1, comprising covering the treatment area with the low density polyethylene barrier prior to light treatment such that a degree of occlusion of the treatment area of at least 85% is provided.

4. The method according to claim 1, wherein the barrier contacts the treatment area.

5. The method according to claim 1, wherein the treatment area is covered with the barrier by conforming the barrier to the treatment area such that the barrier stays close to a surface of the treatment area.

6. The method according to claim 1, wherein the low density polyethylene barrier is held in place with an elastic net.

7. The method according to claim 1, wherein the barrier is covered with material.

8. The method according to claim 1, wherein the barrier is covered with material by placing the material over and around the barrier.

9. The method according to claim 1, wherein the low density polyethylene barrier is removed within 3 hours 18 minutes.

10. The method according to claim 1, wherein the treatment area is wet when the treatment area is covered with the low density polyethylene barrier.

11. The method according to claim 1, wherein the topical composition comprises a gel.

12. The method according to claim 1, wherein the light is red light.

13. The method according to claim 1, wherein the ALA is applied digitally.

14. The method according to claim 1, wherein the ALA is applied with a hand-held device.

15. The method according to claim 1, wherein the treatment area comprises an actinic keratosis lesion.

16. The method according to claim 1, wherein the treatment area is heated by about 2° C. prior to applying light to the treatment area.

17. A method of enhancing penetration of a topical composition of 5-aminolevulinic acid (ALA) into tissue for photodynamic therapy, the method comprising:

topically applying ALA to a treatment area to be treated with photodynamic therapy;

after the ALA is applied to the treatment area, covering the treatment area with a low density polyethylene barrier prior to light treatment such that a degree of occlusion of the treatment area of at least 65% is provided; and

removing the low density polyethylene barrier after 3 hours and then applying light to the treatment area, wherein the treatment area is not heated prior to applying light to the treatment area.

18. A method of enhancing penetration of a topical composition of 5-aminolevulinic acid (ALA) into tissue for photodynamic therapy, the method comprising:

topically applying ALA to a treatment area to be treated with photodynamic therapy;

after the ALA is applied to the treatment area, covering the treatment area with a low density polyethylene barrier prior to light treatment such that a degree of occlusion of the treatment area of at least 65% is provided; and

removing the low density polyethylene barrier after 3 hours and then applying light to the treatment area, wherein the barrier comprises a two layer barrier wherein a top layer provides light pressure to keep a lower layer in place.

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